

# Clarification on HCB Standards and FAQs

---

## Quick Reference

Bedrooms.....	1
Access to Property.....	2
Money.....	2
Food and Mealtime Protocols or Caloric Restrictions.....	2
Injections/Chemical Restraints.....	3
Individual Initiative, Autonomy, and Independence.....	3
Multiple Services Provided On-Site.....	3
Rights Restriction Process and Due Date for Updating Plans.....	4
Guardianship Questions and Responses.....	6

The Behavioral Health Division (Division) reviewed participant plans of care from multiple providers involving practices that do not align with the federal Home and Community based (HCB) service regulations. These practices involve the use of restrictive interventions, including restraints, and do not comply with the federal regulations. **In light of the new federal regulations and the requirement for providers to come into compliance, providers must update all plans of care and positive behavior support plans by February 28, 2016.** The HCBS regulations require that all HCBS providers complete transitions to provide greater participant autonomy and independence in making life choices while limiting the regimentation of the participant's daily schedule and activities. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule, 1-2 (Jan. 10, 2014). The Division is concerned that some providers may not be taking steps to transition toward these new requirements. While CMS has agreed to allow a period of up to five years for these transitions, substantial compliance must be demonstrated continuously during this period. Medicaid Program; State Plan Home and Community-Based Serv., 5-year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Serv. (HCBS) Waivers; Final Rule (Final Rule), 79 FR 3012 (Jan. 16, 2014). Failure to make meaningful steps at this time may ultimately limit a provider's ability to comply with these regulations in the future.

The Division reviewed many plans as a team and want to offer clarity on what will not be allowed in plans of care.

- **Bedrooms.** Under the new federal rules, bedrooms in provider-owned or controlled facilities must have doors with locks. The appropriate staff may have a key to the lock, and the participant must have access to the room and key at all times. If this must be modified or restricted, then the 8 criteria listed in the rule [42 C.F.R. § 441.301(c)(2)(xiii)(A) through (H)] must be met in the plan of care and approved by the Division. Refer to 42 C.F.R. §§ 441.530(a)(i)(B)(1), 441.656(a)(iv)(B)(1), 441.665(b)(3).

Many providers have already made this change organization wide. In response to some concerns in this area, the Division spoke with the HCB setting stakeholder team, and there was no support for an exception to this federal regulation but if there is a need for an exception it will be reviewed at the Division by the Human Rights Team. Having locks and giving participants the option to have a key should not be an extra hindrance to staff responding to the person as needed in the plan of care.

If installing locks on doors is an area being addressed in the organization's transition plan, and a participant does not currently have one, the participant's restoration plan must address the provider's plan to install a

## Clarification to providers on HCB Standards

---

lock and teach them the responsibility of having a lockable door, how to request a key or access the key, and individualize the plan to accommodate the participant's needs.

The Centers for Medicare and Medicaid Services (CMS) answered a question relating to this requirement. The question, "Are there circumstances under which staff or caregivers may or may not enter an individual's bedroom when the door is locked and the individual is in the bedroom?" CMS responded, "Individuals should be afforded the same respect and dignity as a person not receiving home and community-based services. In an urgent or emergency situation, it may be appropriate for someone providing services to enter an individual's locked room. The person-centered planning process and plan should address the circumstances in which this might happen." CMS, HCBS Final Regulations 42 CFR Part 441: Questions and Answers Regarding Home and Community-Based Settings, 5, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>. Lockable entrances do not preclude emergency intervention in provider controlled settings.

- **Access to Property.** Each individual's access to his or her own possessions such as money, clothes, games, hobby supplies, furniture, papers, pictures, etc., is a basic human right. Participants must be allowed the same opportunities to control personal resources, as individuals not receiving HCBS. 42 C.F.R. §§ 441.301(c)(2)(i), 441.530(a)(1)(i). Restrictions will not be permitted unless there is documentation of a direct harm from these items to oneself in their file. Providers must restore all items once the person is safe. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. *Id.* 441.530(c)(iv)(B)(3). A rights restriction to one's furnishings or possessions must be "directly proportionate to the specific assessed need" 441.530(c)(iv)(B)(4). When things are taken away for extended periods of time when the person is no longer a threat of harming themselves or others, the restriction is not proportionate to a need of "keeping a person safe." Positive behavior interventions may not use an individual's own property as a reward.
- **Money.** Money cannot be taken away and earned back through a reward system in a behavior plan, unless the participant and payee or guardian control the rules and the participant can access the money outside of their reward system as needed. Standard monetary rewards as a behavioral device are not compliant with the new rule because people have a right to their money, possessions, furnishings, etc. Payees, guardians, conservators may give weekly or monthly allowances to the person from their benefits. The participant and guardian can decide how the money is accessed, but the money is still the participant's, whether they behave a certain way or not. Waiver services intend for providers to assist a participant with purchasing items and handling cash, depending on the person's needs in these areas. Also, support in these tasks are a great opportunity for participants to receive true HCB experiences.
- **Food and Mealtime Protocols or Caloric Restrictions.** The new federal rules prohibit dietary restrictions or limitations related to individual access to food unless there is a participant specific assessed need that is documented and justified in the person-centered service plan. 42 C.F.R. §§ 441.301(c)(4)(vi)(F), 441.530(a)(1)(iv)(F). Otherwise, "Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time". 42 C.F.R. §§ 441.301(c)(4)(vi)(C), 441.530(a)(1)(iv)(C). Under these rules, participants can be encouraged and educated to eat portion-controlled meals, but they need to have freedom to eat food without undue restrictions or regimens. The plan of care team should discuss and plan services that provide appropriate options for any participants with a medical condition where having access to food might be harmful (like Prader-Willi). An example of an otherwise acceptable strategy might include offering healthy snacks on a regular basis so that the participant has regular access to healthful options.

Also, in accordance with these provisions, food that a person has purchased or contributed to the purchase of cannot be part of their earned rewards in a behavior plan. This food is the participant's property once purchased. Providers may provide trips into the community for snacks as a reward, provided the participant is sufficiently integrated. Providers should also listen to participant input into the food they want to eat, pack for lunch, etc.

## Clarification to providers on HCB Standards

---

- **Injections/Chemical Restraints.** These restraints are allowed in Wyoming rules to be in a plan of care. However, a HCB provider is not an institution and cannot force injections if people are refusing them. The new federal regulations state that settings that “use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion)” are not home and community-based. A compliant home and community based setting allows participants to decline the injection. It cannot be given against their will.
- **Individual Initiative, Autonomy, and Independence.** Persons receiving HCBS should be able to express “individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.” 42 C.F.R. §§ 441.301(c)(4)(iv), 441.530(a)(1)(iv). Therefore, it is inappropriate to require a participant to seek the psychologist’s approval before accessing the community, visiting friends, or accessing other activities in a manner that is not present for people who are not receiving HCB services. A person in HCB services is not in an institution and the role of this team member must remain similar to people in therapy in the community who are not using HCB services. A person not receiving HCB services can freely reject the therapist or psychologist and not face any punitive action unless the treatment is court ordered. Similarly, people receiving therapy, who are not in waiver services and not residing in a psychiatric institution, have options to fully participate in their treatment plans or to skip some visits or recommendations. A psychologist cannot stop the person not receiving HCB services from going to work, meeting with a friend, or going to a community store. Such restrictions would violate the provisions of 42 C.F.R. §§ 441.301(c)(2)(i), 441.301(c)(4)(vi)(C), 441.530(a)(1)(i), 441.530(a)(1)(iv)(C).

In accordance with §441.301 on person-centered service plans, a person on the waiver must have a person-centered plan of care developed and driven with their input and the input of the individual plan of care (IPC) team. 42 C.F.R. § 441.301(c)(1), (2). The individual and guardian, if applicable, must express informed consent in writing, and all individuals and providers responsible for implementation of the plan of care must sign it. *Id.* 441.301(c)(2)(ix). The plan must also prevent the provision of unnecessary or inappropriate services and supports. *Id.* 441.301(c)(2)(xii). The plan must “reflect that the setting in which the individual resides is chosen by the individual.” *Id.* 441.301(c)(2)(i). The setting must be integrated in the greater community and support full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. *Id.*

When the plan of care has restoration plans and protocols requiring a staff person or psychologist’s approval before an individual can work, access food, or go into the community, attend religious and cultural events, these practices raise red flags that the plan of care is not developed using a person-centered standards required in the regulations. If the participant or guardian chooses to include a psychologist in meetings and the plan development process, those items that under psychologist control must be discussed during the meetings so the team can all give input. The participant and guardian must agree to the items and right restriction in the behavior plans. The Division will not approve plans that do not incorporate the participant’s preferences because these plans are not person-centered.

- **Multiple Services Provided On-Site.** The new regulations state that settings “designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities” have the effect of isolating individuals from the community. These practices are not HCB. CMS, Guidance on Settings that Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community, 1, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf>.

After reading the latest CMS letter on heightened scrutiny from a case in North Dakota, we are learning more about CMS’ expectations in this area with the latest round of information released by them, and this may affect the transition plans for the some day service sites. As we have said previously, the efforts to remedy the issues

## Clarification to providers on HCB Standards

---

at these facilities must involve actively helping participants receive services off site, not just offering choice. This was discussed in our HCB Transition plan meeting. In the North Dakota Heightened Scrutiny case, CMS found that “the Day Program setting does not meet the characteristics of home and community-based because the majority of individuals receive most of their services at the facility-based program and are not integrated into the greater community. Therefore, the state must take significant action to ensure greater community integration during the transition period, including providing increased opportunities for individuals to participate in community-based, rather than facility-based work, activities, and services and supports if the state wishes to continue using this setting for home and community-based services.” This letter can be found at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/nd/nd-cmia.pdf>. As providers develop action items in their transition plan, please refer the CMS guidance for assistance in the changes to your program that will be required.

### **Rights Restriction Process and Due Date for Updating Plans.**

Plans of care need to be updated by Feb. 28, 2016 to reflect the new regulations for restricting a person’s right. If a provider is not changing a practice in their system by Feb. 28, 2016, such as locking all food, then the provider must help the team have the appropriate information explained in the plan of care to meet these eight (8) requirements in accordance with 42 C.F.R. § 441.301(c)(2)(xiii)(A) through (H):

1. Identify the specific and individualized assessed need.
2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

### **How do providers keep participants safe when eliminating restrictions they have had in place?**

Waiver participants will likely need support, education, mentoring or coaching from their IPC team members on making good choices and understanding natural consequences, which is why they qualify for waiver services, but the restrictions on rights should not keep them from living life and making adult decisions if they are 18 or older. A guardianship or waiver program should not take away their rights to be an adult and be empowered to pursue a life that is chosen by them and according to their preferences, values and desires, not the desires and values of everyone around them. If participants have had restrictions in place for several years, and now those restrictions are lifted due to these new rules, there must be responsible teaching and action steps in place so that the participant is not set up to fail. With all of the new freedom (to food, mail, phone, visitors, etc.), the participant may make a bad choice – but should receive support and training to mitigate the risks that the team is worried about. And yes, the participant may fail at something or have a close call, but these are training opportunities and should be areas that are explored through “habilitation” or “training” services. Then, as things are taught and attempted, the team needs to document what happened and if it was effective or not. We all need to encourage lifelong learning, which happens through real-life experiences.

### **What is the Division's role in reviewing restrictions to rights?**

The Division needs to ensure a person’s rights are respected and upheld by providers in accordance with federal and state rules. Therefore, all restrictions to rights must be written into the plan of care so they can be preapproved before they are in place. Even if restrictions were approved in past plans of care, the new rules require Division staff to review all restrictions according to the new federal standards and push back on the teams to reevaluate the need for them when deemed necessary.

## Clarification to providers on HCB Standards

---

### **What if the restriction is temporarily or occasionally imposed, what should the restoration plan in the IPC include?**

In these instances, the restoration plan must include time limits for periodic reviews to determine if the modification is still necessary or can be terminated, and:

- How to assist the participant with exercising their rights more fully
- How the team will ensure that a participant's rights are not completely removed
- Identify what part of the right is restricted
- Set goals for restoring the right(s) (*through participant training*)
- Include time limited restrictions

Waiver services should include training and teaching time or support with the participant to assist and guide with restoring rights and include strategies in the support section or behavior plan that can encourage more independence with the specific right.

### **What if the provider isn't following the PBSP and restrictive interventions?**

A provider that is not following the PBSP must talk to the case manager and parent/guardian about why they are not following it. If they don't agree with it, then maybe the PBSP should not be in place or the provider is appropriate for the child. If it is too complex, then the major behaviors or effective techniques for working with a person should be included and the others are removed. Some may turn into "supports" in the needs, risks and restrictions area. If the provider does not ethically believe in the interventions listed or their policy doesn't allow for certain interventions, the guardian may need to decide if the provider is the appropriate choice or if the intervention can be removed in order to appease the provider and keep the participant in their services. Whichever decision is made, the IPC team needs to advocate what is best for the participant above all else.

### **What if so much is removed that the PBSP is so watered down that it won't be able to be followed or be useful?**

The new rules want the restrictions to be reasonable and appropriate and not a "first resort" to modifying behavior. A positive behavior support plan should really focus on the positive, effective ways that a person should be supported prior to restrictions and even if they have to live with certain restrictions. The removal of restrictions in the PBSP will likely need to be replaced with training objectives or new supports that are written into the plan of care. The providers and guardian must make responsible decisions in how to introduce back rights to a person that has typically lived with them being restricted.

### **If there is a restriction on a lease agreement, does this then have to be listed in the plan as a restriction and then on the PBSP?**

Yes, they must be listed as a restriction and in a PBSP, until the Crisis Intervention Protocol is established. A provider's house rule that restricts visitors, decorations, possessions cannot take away a person's rights without the person being allowed to have input into the decisions, having the right to ask for a variance on the rule if there is a good reason, and if the restrictions prevent the participant from having autonomy and preferences honored in their home or other service environment.

### **If there is a provider policy or QIP that thus results in a restriction, how do we handle this?**

The provider must explain how they will allow for participant input into their policies and rules if any of their rules are preventing the person from having something or doing something that is a) their preference and b) in their best interest to allow (not harmful). This goes back to enforcing a "least restrictive" environment for those served on the waivers in community based settings.

### **Will we have to revisit the rights that are restricted on a current plan of care, even if they have been approved in the past?**

Yes. By February 28, 2016 all plans of care must be updated to document any rights restrictions according to the new federal standards. The team must look at why a restriction is in place, determine what other strategies have been tried and if there others that could be tried so the restriction can be lifted or become less restrictive. Participants should be allowed to take risks, make choices, and have support and training so that the risks are



## Clarification to providers on HCB Standards

---

lessened and the opportunities for exercising their rights and freedoms are respected. The legally appointed guardian and providers should not impose their own value system on the participant. The team should help the participant develop a plan that eliminates unnecessary restrictions and barriers that will keep the participant from achieving the vision they have for their life. The new federal rules are about ensuring that HCB services are not imposing a restricted, isolated, regimented, institutional lifestyle on a person simply because they are receiving Medicaid services or they have a developmental disability or mental health condition. Any restriction must meet a specific need, as described above.

### Guardianship Questions and Responses – originally posted 7/24/2015

- 1. With these changes, it seems that a guardian's rights are changing. What are the guardian's rights?**  
It is important to first understand the person's rights when he/she has a guardian. According to the Wyoming Guardianship Statute, "The ward under any guardianship or conservatorship shall have the right to the least restrictive and most appropriate guardianship or conservatorship suitable to the ward's circumstances, subject to the order of preference provided by W.S. 3-2-107 and 3-3-105 and the least restrictive and most appropriate residential, educational and employment environments." Decisions made should be the **least restrictive and most appropriate**. The specific guardianship court order explains the rights for each guardian, but they may be written very broadly. This is why reading the Division's Guardianship guide or watching our training for guardians helps to tease out what guardians should do on a more specific level when it comes to waivers.
- 2. To what extent should the guardian make day-to-day decisions for their ward?**  
One way to describe the rights of a guardian is that the court appoints the legally appointed guardian to make "macro" decisions for their ward in the areas of medical care, providers, education, etc. In this higher level of decisions, the guardian should take the participant's preferences and input into consideration as to not take away the participant's rights to make "micro" decisions on a daily basis regarding activities of daily living, such as choosing what to wear, who to talk to, what to eat, where to go, what to do, unless there are necessary restrictions to those things based on a specific assessed need due to the person's diagnosis or condition or a risk of imminent harm to the person (in which case the 8 requirements in the new federal regulations must be addressed and documented in the plan of care). A person under guardianship should still be allowed autonomy and choice and have their interests and preferences acknowledged and respected by their guardian and IPC team. As the guardian makes decisions (with input from the team) on behavior supports, restrictions, or activities, but the participant's preferences or choices are not included, then the participant is probably not receiving person-centered services that are the least restrictive and most appropriate.
- 3. Can rights still be restricted by the Guardian?**  
Yes, rights may still be restricted by the Guardian in some instances, depending on the circumstances and justification for the restriction(s). The new federal rules do allow for a modification/restriction to the right as long as it is done in compliance with § 441.530(a)(1)(vi)(F) and § 441.710 (a)(1)(vi)(F):  
*(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:*
  - (1) Identify a specific and individualized assessed need.*
  - (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.*
  - (3) Document less intrusive methods of meeting the need that have been tried but did not work.*
  - (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.*
  - (5) Include regulation collection and review of data to measure the ongoing effectiveness of the modification.*

## Clarification to providers on HCB Standards

---

*(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.*

*(7) Include the informed consent of the individual.*

*(8) Include an assurance that interventions and supports will cause no harm to the individual.*

These eight (8) requirements must be met before limiting or modifying the rights of any individual, including possessions and how they furnish or decorate their living area. To clarify regarding condition #1 of a specific and individualized assessed need: The Division will not allow the presence of a condition or diagnosis to be enough to restrict the right all together, to an extreme by taking away all or almost all possessions, or restricting without a reasonable end date. Perceived rights restrictions for medical or health needs that are actually lifelong support needs can be addressed through the *Needs, Risks, and Restrictions* area and possibly in a positive behavior support plan, without *restricting* the person's right.

If a person's possessions may be used by the person to cause oneself or others harm, then the right may need to be restricted. If this is the case, the eight (8) conditions must still be met. Some of the restrictions we are seeing on plans go against person-centered planning practices, which is another requirement of the federal regulations: "The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports."

If a guardian or provider imposes a monetary restriction on a participant, which may economically confine a person in an institutional manner from being able to access the community or partake in their preferred activities, then the restriction or behavior system based upon a monetary reward will not be allowed.

If a person's behavior plan involves a reward of food that the person should have access to anyway, the Division will not approve the plan.

A restriction cannot be based solely on a diagnosis, medical condition or a possible behavior that happens on occasion. Health and safety concerns addressed by a restriction must not be based on general fears or concerns because of the person's disability or be based on provider convenience because of other people served in the home. Any modification or restriction of a right must meet the federal requirements by February 28, 2016, but as plans are being reviewed now, the Division is asking case managers to re-look at many restrictions that may have been in plans for several years. If a restriction is in place due to guardianship and it may be life-long, the restriction must still be reviewed to see how the person can exercise the right to the fullest extent possible. This information may go in the Supports section of the IPC. The restriction must have a restoration plan that explains when it was last reviewed, why/if it is still appropriate, and when it will be reviewed again (at least annually) to see if the person has learned and demonstrated skills to have the restriction lifted.

#### **4. Can a guardian restrict a person's access to a phone or restrict phone calls, the right to access food and drink, and send and receive mail?**

Sometimes! There may be a reason that a guardian restricts access to those items if the person under guardianship has acted in a way that may harm themselves or others by exercising those rights without a restriction. But the requirements to restrict the right listed in # 2 still apply. The plan of care must address what happened in the past and why the restriction is still needed. However, since individuals can learn new skills and possibly overcome certain mistakes of the past, the restriction should not be "lifelong" to the same extent that it is restricted today. By implementing supports, training and outlining how the person can exercise the right to access these things to the fullest extent possible, the person may be able to get the restricted lifted (even partially) in the future. The guardian may have the authority to restrict many of these things due to the court order, but the guardian, case manager and waiver providers have a responsibility to the participant to ensure everyone is respecting person-centered philosophies and

## Clarification to providers on HCB Standards

---

serving the person in a manner that respects who they are, what they prefer, likes and dislikes (What is **important** to the person), as well as what is **important for** the person. The provider must also agree to implement the restriction, since some providers may not be willing to impose certain restrictive interventions onto participants. Teams may need to compromise on what can be done based on the setting that is chosen and the provider(s) that are chosen.

If the restriction is listed in the plan without proper justification or the 8 criteria met, the Division will roll it back without approval so the team can meet to discuss the restriction and see if there is other information or strategies that should be included prior to the restriction being allowed. The Division may also involve the Division Psychologist to review the behavior plan for more guidance and suggestions.

An area where the Division will likely need more information is if a person is required to be on a strict diet or have food locked up. These type of restrictions need a doctor's input and documentation so there is more context and justification to the type of restriction and also so the restriction is only implemented to the extent necessary for the person's health and safety—and not overly restrictive for provider convenience or the needs of others in the same location.

When a participant's behavior may cause harm to the person or others, and the restrictive intervention imposed may be a restraint, the guardian (and IPC Team) who is requesting or authorizing this level of intervention from a community based service provider may be encouraged by the Division to review our Positive Behavior Support Plan Workbook for additional strategies and guidance. The Division may also talk to the case manager and guardian about getting their guardianship court order updated to add more specific authority to authorize the use of restraints on their ward due to the very restrictive nature of this type of support in a non-institutional setting.

### 5. **How does a guardian or IPC team know if a health and safety concern should be addressed through a "support" written into the plan versus a "restriction" of a right in the plan? And could there be both?**

The Wyoming Guardianship statute says the guardian shall determine and facilitate the least restrictive and most appropriate services. What is least restrictive to one person may not be least restrictive to another. Furthermore, justification for one person's restriction may be enough for that person to get it approved but it may not be enough for a different person, depending on the other assessed needs, abilities, and strengths of the waiver participant. For additional guidance on "least restrictive", refer to the National Guardianship Association (NGA) standards:

#### *NGA Standard 8 – Least Restrictive Alternative*

- I. The guardian shall carefully evaluate the alternatives that are available and choose the one that best meets the personal and financial goals, needs, and preferences of the person under guardianship while placing the least restrictions on his or her freedom, rights, and ability to control his or her environment.
- II. The guardian shall weigh the risks and benefits and develop a balance between maximizing the independence and self-determination of the person and maintaining the person's dignity, protection and safety.
- III. The guardian shall make individualized decisions. The least restrictive alternative for one person might not be the least restrictive alternative for another person.
- IV. The following guidelines apply in the determination of the least restrictive alternative:
  - A. The guardian shall become familiar with the available options for residence, care, medical treatment, vocational training, and education.
  - B. The guardian shall strive to know the person's goals and preferences.
  - C. The guardian shall consider assessments of the person's needs as determined by specialists. This may include an independent assessment of the person's functional ability, health status, and care needs.



## Clarification to providers on HCB Standards

---

The NGA ethical guidelines go on to say: When the preference of the ward will result in harm, the guardian shall make decisions with respect to care, treatment and services which are in conformity with the best interest of the ward. For more information on the National Guardianship Association's (NGA) standards of practice, visit [http://www.guardianship.org/documents/Standards\\_of\\_Practice.pdf](http://www.guardianship.org/documents/Standards_of_Practice.pdf).

**6. How does a case manager know if the guardian has the authority to make certain decisions, since many court orders have canned language and are rather vague?**

Vague or canned guardianship orders that seem short or nonspecific to one's cases likely mean the guardian is given full authority for medical, educational, and social needs of the participant, rather than implying less authority. Guardianship or conservatorship orders that are restricted to certain categories of decision-making specify the restriction in the court order. If the court order does not mention any restriction--that means the guardianship is plenary (absolute) in nature.

This has been a sensitive subject in the past and the Division has not been clear on this topic. Hopefully the previous paragraph clears up some confusion. We want to stress, however, if a guardian has full authority to implement restrictions, the Division believes they also have full responsibility to ensure they are acting in the person's best interests, taking into account the person's preferences and goals, and making decisions that are the least restrictive and most appropriate. If the guardian cannot provide adequate information or justification for a restriction and the team is not in agreement with the restrictions, the team members should bring up their concerns prior to signing the plan of care and agreeing to provide services. Some historical restrictions that have been in place for years may be questioned since they may not have adequate justification, in which case the guardian and team must discuss all of the options available to allowing the person to have the right (to the fullest extent possible), summarize what has been tried in the past, how those situations turned out, and what else providers can work on in the future to support the person in this area. These steps must be followed to restrict a right, but are not a way to take any authority away from guardians. The steps ensure the participant's rights stay prioritized and respected during the service planning process and that case managers and the division properly advocate for the participant above all else.

**7. What are some strategies to address the Division's new rights restrictions to guardians? It seems like the Division is taking away guardian's rights, and guardians are anxious about this.**

The Division is not taking away a guardian's rights, if they have the right to make certain decisions for their ward. The Division is asking teams, including case managers, to question certain restrictions or plan of care protocols if they do not align with the new federal HCB rules for restricting rights and making person-centered planning decisions. If there is not justification for restrictions to be in place, they must be removed, even if they were made by the guardian. If the plan of care does not address why a restriction is in place, we cannot approve it. If teams and providers need more time to comply with the new requirements, they can work with their PSS on these extensions so they are documented in EMWS. The deadline for updating plans to align with the new rights restrictions requirements in the federal rules is February 28, 2016.

**8. How can case managers and providers talk to guardians about these changes?**

Guardians may need to be pointed to training opportunities or may need to talk through these changes if they are disagreeing with the new rights and restriction requirements in plans. BHD and WGC teamed up to create a Guardianship handbook and training, available on the BHD website: <http://www.health.wyo.gov/ddd/index.html>. The National Guardianship Association's (NGA) standards of practice are found at [http://www.guardianship.org/documents/Standards\\_of\\_Practice.pdf](http://www.guardianship.org/documents/Standards_of_Practice.pdf). Case managers, providers and state staff have to be sure that guardians have the authority to make certain choices, so they will review guardianship papers and the guardianship statute to double check. The guardian and IPC team should discuss the following questions:

- Why is this restriction needed?
- What have we tried before to avoid restricting the right? (*where is this documented*)

## Clarification to providers on HCB Standards

---

- Do we really know what will happen if this right is fully respected (*not restricted*)?
- What can we teach or how can we support the person to exercise the right safely without restricting it?
- If the right will continue to be restricted, does the guardian have the authority to authorize the right to be restricted?
- Is this restriction imposed only when absolutely necessary?
- Is there a training objective during services to help a participant exercise their right in a safe and healthy manner so the risk and restriction can be avoided?
- When was the last time other interventions and supports been tried to help the person exercise their right without restrictions? (*Maybe it is time to try other approaches!*)

If the team has not discussed these questions, then the right is likely restricted without good evidence to support it. Case managers should use this same scrutiny during the plan development process as Division staff use when they are talking with the IPC team members. The plan will need to show more documentation of what was discussed, tried, and what will be tried so that restrictions, especially due to behavioral issues, become a last resort.

### **9. If a right is restricted due to a guardianship order, what should the restoration plan be, especially when the restriction will be life-long due to the person's need for a guardian?**

The intent of a restoration plan is to honor a person's ability to learn new skills, learn new information, and gain the control to make more decisions in his or her life. If a restriction looks like it will be lifelong due to the need for a guardian, the restoration plan may look different than a restriction that is only imposed occasionally or until the person learns certain skills. Lifelong restrictions due to guardianship should have a restoration plan that explains when the restriction will be reviewed by the team and if new or different supports or level of independence or control can be given the participant to exercise the right to the fullest extent possible. The team should review the restriction annually at a minimum and discuss any changes to the supports needed in that area to maximize the amount of control or choice the person may still be allowed. The review and the results of the review should be updated in the restoration plan annually.

### **10. What are some things guardians should and should not do?**

Here are excerpts from the BHD Guardianship guide. A Guardian SHOULD:

- Ensure that the ward receives benefits to which he or she is entitled to under public programs.
- Allow the ward the opportunity to manage his or her own personal funds to the extent that he or she is able.
- Allow the ward to be a part of all decision making to the extent that he or she is able.
- Make all decisions in the participant's best interest. In providing informed consent for treatment, a guardian must show good judgment in reviewing any relevant "risk and benefit" information related to treatment, medications, services, and medical interventions. Informed consent decisions need to be made on a timely basis.
- Play a key and active role on the support team and participate in finding solutions and compromises when differences occur.
- Be supportive of the participant's role on the team and help the team understand the desires and choices of the participant.

A Guardian SHOULD NOT:

- Have a conflict of interest
- Make decisions without consulting the participant
- Make decisions where the court has not given authority

### **11. Does a doctor's script supersede a guardian's right? We ask this because when a doctor prescribes something whether it is a new medication or a procedure, the guardian has a right to say no. Thus**

**really a guardian has more rights than a doctor. However, from what we have understood if a guardian wants to restrict this, we need a doctor's script? Again doesn't really match with the laws.** This will always be a complicated area. Medicaid services require medical necessity and waivers allow for functional necessity as well as medical necessity. However, guardians may be able to override medical treatment recommendations if they have a justifiable reason and it is in the person's best interest. Doctors sometimes write orders for waiver services that are not really in their domain of expertise to recommend, such as an order for "day hab". In these cases, the Division PSS's are instructed to ask for more information to show how the team is working to make a plan that is in the best interests of the participant. If the team, including the case manager do not think the guardian is acting in the best interest of their ward, the case manager should work to reeducate the guardian on the requirements of waiver services and person-centered planning. The case manager can loop in the Division PSS if they need consultation on what to do.

**12. How do these new rules apply to children?** We use the same rules. However, we do not get involved in what parents want to do with their children. But if a parent is making a provider do something that is against the current rules or rights of children, we will not approve those restrictions in the plan. We recommend that parents recognize that providers do not have the same authority over children that parents do, so there are differences in the type of discipline or restrictive interventions they can ask the provider to do. If they don't want certain foods to be given to their child or they have specific cultural or family traditions with food or other daily activities, those should be listed in the preferences in the IPC and supported by the provider during services. If the provider is asked to deny or restrict possessions from children, we suggest that the family not make those items available to the provider during services so that the provider is not implementing restrictions beyond their authority.

**12a. If there is a restriction, do we need to have a PBSP for every restriction?** Only for restrictions implemented as a way to modify the child's behavior. If it is a support need, not a restriction, then the instruction will be placed in the needs, risks, and restrictions area that is applicable. If the restriction is due to a family value/tradition/belief, such as eating kosher foods, gluten free foods, etc., this is a preference and some "supports" may need to be listed in the needs and risks area to ensure providers know what is allowable. Sometimes a separate meal or food protocol is needed.

**12b. What if the plan has 10 restrictions?** If there are 10 restrictions in a plan, and the team is struggling with how to honor the intent of the new rules with all of the restrictions, then the team should discuss what is a reasonable request for the provider to follow? Is there a way the parents can eliminate certain temptations or triggers that cause the child behaviors before the provider starts providing services, such as removing the junk food or soda that they have decided the child should not have or video games that need locked up. If there are dietary restrictions due to a family decision (to be gluten free, organic, no glucose, etc.) then the food choices should be listed as a support and the provider should not provide access to food the family doesn't agree with.